Event: Briefing on Polio – Update 3 on Declaration of Public Health Event of International Concern by World Health Organization

Notified by: Immunisation Division, PHE Centre for Infectious Disease Surveillance and Control (CIDSC)

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Background and Interpretation

The World Health Organization (WHO) originally issued a statement on 5 May 2014 declaring that the recent international spread of wild poliovirus was a Public Health Emergency of International Concern (PHEIC). Temporary Recommendations were issued for exporting and infected countries under the International Health Regulations (2005) (IHR). An earlier Briefing Note 2014/074, 3 October 2014 identified the recommendations for travellers from England, Wales and Northern Ireland to affected countries.

WHO have recently reassessed their Temporary Recommendations and this briefing note outlines the implication of this updated review. Key conclusions are the rising risk of WPV1 international spread (from Pakistan and Afghanistan). Afghanistan and Pakistan remain endemic for wild poliovirus type 1 with recent detections in 2019. Progress in Nigeria has been more positive with the most recent detection in 2016. All three countries continue to follow WHO advice to provide OPV to travellers who are unvaccinated on departure. The WHO also noted the rising risk of cVDPV spread in a number of other countries linked to falling PV2 immunity.

Routine polio vaccine uptake in the UK is high and has been sustained at this high level for many years. The last indigenous case of wild poliovirus infection was in 1984 and the UK, along with the rest of the WHO European region, was declared polio-free in 2003. The risk of importation and local transmission of wild or vaccine-derived poliovirus from visitors from infected countries remains extremely low. However, there continue to be implications of the WHO recommendations for the UK, as the UK has significant numbers of travellers to and from affected countries.

The UK has a strong polio surveillance programme and it is important these enhanced surveillance activities continue.

The approved recommendations for immunisation of travellers to affected countries from England are outlined in the Appendix. This is intended to be a specific communication that can be cascaded through SILs to primary care and other partners.

Implications and Recommendations for PHE Centre Screening and Immunisation Leads (SILs) and Health Protection Teams (HPTs)

There are a significant number of long-term visitors to affected countries. PHE Centres may be asked for advice about travel to affected countries. As per normal arrangements, travel advice for professionals and the public should be obtained from the National Travel Health Network and Centre (NaTHNaC). NaTHNaC continues to update its travel advice and country information pages in line with current recommendations [2].

PHE centres should continue to advise relevant stakeholders that all those at risk receive appropriate advice prior to long term (>4 weeks) travel to affected countries and to ensure appropriate immunisation with polio vaccine as per guidance is undertaken. In particular, long term travellers who are contra-indicated to OPV (because of immunosuppression, as a family contact or pregnancy) should receive inactivated polio-containing vaccine prior to departure. This is to reduce the risk of them being given OPV in country.

Health protection teams should continue to be alert to the possibility of polio infection including both mild/non-paralytic febrile illness and meningéal, neurological or paralytic illness in recent arrivals from affected countries. Acute poliomyelitis is a notifiable disease by law and all suspected cases should also be formally notified to the proper officer in the normal way. Further information and advice for health professionals [4] is available.
Screening and Immunisation teams should examine coverage of primary vaccinations at age 12 months and 5 years for those areas with large populations with close links to the major affected countries. Areas with sizeable populations where primary vaccination uptake remains below 90% at the age of five years may need to consider supplementary vaccination activities. For populations where coverage exceeds 90% by age five years but may be lower in younger age groups, clinicians should be alerted to the need to use all opportunities, such as travel abroad, to ensure timely vaccination, and to improve coverage in these populations.

Implications for Local Authorities

This PHE briefing note is unlikely to have any direct impact on Local Authorities. Any enquiries should be directed to the local PHE Centre Health Protection team.

Recommendations to Public Health Laboratories

There is a need to raise awareness about testing for enteroviruses for all NHS microbiologists. As outlined in the polio surveillance SOP [3] CSF and faecal samples should continue to be tested locally and any enterovirus positive samples from a person with relevant symptoms sent to Colindale for typing. A request form for referral of samples to Colindale is available from the Virus Reference Department.

Communications activity

Together with NaTHNaC, national PHE communications at Colindale have developed messages to the media and the public with regards to the international situation and to confirm the updated guidance with regards to vaccination of long-term visitors to infected countries. PHE Centres that consider any supplementary vaccination activities should liaise with their regional/Centre communications team for advice on media/stakeholder activity to support this.

References/Sources of information